

FEMALE CONTRACEPTIVE VISIT FORM

CC: _____

Tobacco use : _____ Allergies: _____

Meds: _____

G ____ P ____ #LC ____

Age ____ BP ____ Wt ____

Temp ____ Pulse ____ Ht ____

Annual Exam Due: _____

HPI/ROS: _____

PMH/SH/FH: ☐ reviewed Medical History Form and ☐ no change, or changes per below:

Contraceptive History

LMP _____ Date last pregnancy ended _____ Lactation? ☐ yes ☐ no Desires Pregnancy? ☐ no ☐ yes

Current BCM _____ Used as prescribed? ☐ yes ☐ no, _____

If injection BCM, ☐ N/A, last one given ≤ 13 weeks or ≤ 33 days ☐ yes ☐ no, _____

Amenorrhea? ☐ yes ☐ no Bleeding between periods? ☐ no ☐ yes, _____

Any new symptoms or problems? _____

Any ACHES Sx? ☐ N/A ☐ no ☐ yes, describe: _____

Satisfied with current BCM ☐ yes ☐ no, explain: _____

UPIC past 14 days ☐ no, then Contraceptive Hx complete ☐ yes, describe: _____

UPIC past 5 days ☐ no ☐ yes, wants ECP? ☐ no ☐ yes, _____

Hours since UPIC ☐ <24 ☐ 24-48 ☐ 49-72 ☐ 73-120 (less effective) ☐ >120 (not effective)

UPIC reason: ☐ condom broke or slipped ☐ missed OCPs ☐ no method used ☐ Other: _____

Multiple UPIC ☐ no ☐ yes, still wants ECP and is aware it can fail? ☐ yes ☐ no

STD Concerns ☐ no ☐ yes ☐ n/a

Past STD History _____

Current STD Symptoms _____

Sx in partners _____

Exposure _____ # partners/2 months _____



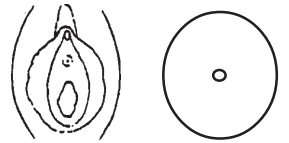
Public Health
Seattle & King County

Chart Label

General	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Breasts	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



Lymph Nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Urethra/Bladder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vulva	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vagina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cervix	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Uterus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Ant <input type="checkbox"/> Post <input type="checkbox"/> Mid Size _____
Adnexa	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rectum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



☐ UCG neg pos ☐ pH _____ ☐ KOH neg pos ☐ Urine _____
☐ Hct/Hgb _____ ☐ WHIFF neg pos ☐ Saline _____ ☐ Gram _____

☐ PAP ☐ GC ☐ RPR ☐ Hep C ☐ Urine culture
☐ CT ☐ HIV ☐ Hep B ☐ HSV ☐ Other

<input type="checkbox"/> Contraception _____	<input type="checkbox"/> Preconception counseling	<input type="checkbox"/> Calcium/Exercise/Nutrition/Iron
<input type="checkbox"/> Back up method for 1 or 2 weeks	<input type="checkbox"/> ECRR teaching done	<input type="checkbox"/> Obesity
<input type="checkbox"/> EC availability/use/side effects	<input type="checkbox"/> STD/HIV Prevention	<input type="checkbox"/> Cervical Cytology/HPV
<input type="checkbox"/> Advance provision ECP <input type="checkbox"/> Refused	<input type="checkbox"/> Substance use	<input type="checkbox"/> Breast self-exam/Screening
<input type="checkbox"/> BCM Specific Consent Form	<input type="checkbox"/> Tobacco Cessation	<input type="checkbox"/> Other _____
<input type="checkbox"/> Estrogen product teaching to include 1st day start, side effects, how to use STD protection, thrombosis danger signs		

Contraceptive Management: ☐ no contraindications to method. Risks and benefits discussed. _____

Method/brand: _____ May use for _____ months/cycles, then needs ☐ annual visit, or needs ☐ revisit and if normal visit (☐ with provider) then _____ more months/cycles may be given. ☐ Package insert given.

ECP ☐ Plan B or _____ ☐ emergent ☐ advance and ☐ may refill as needed.

Injection: ☐ DMPA ☐ Lunelle Site _____ Lot # _____ Signature _____ Next shot due _____

Same day start/restart hormone method or ECP ☐ no ☐ yes, client aware of risk early pregnancy, need to return for

☐ See Medication Sheet for prescriptions

Plan/Follow-up:

_____ / _____	Chart Label
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RN/MA/Health Educator	Provider	Date	
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